METHODOLOGY AND GUIDELINE DEVELOPMENT ISSUES

MGB1

POOR ADHERENCE TO HYPERTENSION TREATMENT GUIDELINES: AN ANALYSIS OF THERAPEUTIC CHOICES

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The recent Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) reiterated long-standing recommendations that Stage 1 hypertension (BP $\geq$ 140/90 mmHg) without comorbidity should be treated initially with diuretics (DI) or beta blockers (BB). Yet market research suggests that many physicians prefer to use other drug classes, such as calcium channel blockers and ACE inhibitors.

OBJECTIVES: To explore the determinants of therapeutic choice in hypertension.

METHODS: We surveyed by mail a stratified random sample of 10,000 U.S. cardiologists, internists, and family/general practitioners. Physicians were queried about their practice environment and their knowledge, attitudes, and practices regarding antihypertensive therapy, including their choice of drugs to treat patients with specified clinical profiles. The probability that physicians would follow JNC guidelines Stage 1 hypertension was analyzed using multiple logistic regression with stepwise backward elimination to select variables with $p < 0.001$.

RESULTS: Completed surveys were received from 1,023 physicians. 86.7% prescribe drug therapy for Stage 1 hypertension, and 19.5% (22.5% of drug prescribers) limit their choices to DI and BB. Guideline conformity was higher among physicians who: practice in academic medical centers; are older; are general practitioners (versus general internists); have smaller caseloads; have fewer hypertensive patients; have higher proportions of HMO, Medicaid, and uninsured patients; and experience more formulary restrictions. Cardiologists and family practitioners were less likely than internists to follow guidelines.

CONCLUSION: JNC guidelines are better accepted by academic physicians, older physicians who have more experience using DI and BB, physicians with smaller caseloads and

hence more time for follow-up and therapy adjustment, and physicians who face drug reimbursement constraints.

MGB2

THE UTILIZATION AND COSTS OF PRESCRIPTION DRUGS IN A TEXAS MEDICAID MANAGED CARE PILOT PROGRAM

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The state of Texas established a Medicaid Managed Care Pilot Program in Bexar County on September 1, 1996 for clients previously in a Fee-For-Service (FFS) plan. Clients selected either a health maintenance organization (HMO) or a "gatekeeper" physician through a primary care case management (PCCM) plan.

OBJECTIVE: This study evaluated the changes in prescription utilization and costs when FFS clients entered into either an HMO or PCCM health care delivery model.

METHODS: Prescription drug claims were analyzed for Aid to Families with Dependent Children (AFDC) clients eligible for both a pre-implementation period (December 1, 1995–May 31, 1996) and a post-implementation period (December 1, 1996–May 31, 1997). A total of 59,377 HMO clients and 67,451 PCCM clients were studied. Three control sites were selected consisting of Medicaid clients in FFS, HMO, and PCCM plans for both study periods in other geographical locations across the state. Changes in the utilization and costs of prescriptions per month were measured for each client between the pre- and post-implementation periods.

RESULTS: One-way analysis of variance showed that the mean change in monthly prescription costs per client was highest between periods for clients in the PCCM experimental group ($4.61, s.d. = $44.63), followed by HMO clients in the experimental group ($2.10, s.d. = $26.21). These cost increases were significantly higher than those in the HMO ($0.68, s.d. = $34.91), PCCM ($1.44, s.d. = $42.40), and FFS ($1.05, s.d. = 21.86) control groups ($p < 0.001$). The percent of prescriptions dispensed as generics increased across periods in all groups, except for the PCCM experimental group.

CONCLUSION: Prescription drug costs may increase when FFS Medicaid clients enter an HMO or PCCM health care delivery plan.

MGB3

POSTMARKETING OUTCOMES STUDIES: BENEFITS AND RISKS

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OBJECTIVE: To consider the benefits, financial risks, and opportunity costs of large postmarketing outcomes studies as demonstrated by studies of the statin drugs.

METHODS: Literature review.

RESULTS: *Benefits*: The studies definitively showed that the drugs and lowering lipids were safe and efficacious. The studies also expanded the indications for the drugs, generated goodwill in the medical and research communities for the sponsors, allowed them to include specific claims about the drugs in their advertisements, generated follow-up studies, and spawned economic analyses that extended interest in the drugs in both the medical and lay press and had a major impact on the clinicians' use of the drug. *Risks*: The studies had a strong coattails effect. Each new study was beneficial to all the statins as well as the one studied. Economic analyses after some of the studies concluded that although the drugs effectively lowered cholesterol and prevented clinical events, use of the drugs was not cost-effective. Many studies took a long time, and it often took even longer for the results to be assimilated, to be put into perspective, and to influence other researchers and clinicians. During that time, the sponsoring companies shouldered opportunity costs as well as the actual costs of the studies. The risk that one drug company would use another company's results instead of investing in their own research did not materialize. All the major pharmaceutical companies with statins conducted their own postmarketing outcomes studies.

CONCLUSION: How a company weighs the risks and benefits of strategic studies may depend on its time perspective. In the short term, the risks may outweigh the benefits. Only those companies that have a longer perspective may find it beneficial to undertake a large postmarketing study.

MGB4

RELATIONSHIP BETWEEN QUALITY OF LIFE, DISEASE SEVERITY, AND PHYSICIAN VISITS IN MANAGED CARE PATIENTS WITH ATOPIC DERMATITIS

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The relationship between disease severity, quality of life (QOL), and resource use in patients with atopic dermatitis (AD) has not been well explored in a managed care population. As the overall lifetime incidence of AD is 15–20%, this represents a substantial burden to the healthcare system.

OBJECTIVE: To investigate how severity of illness assessed via chart review relates to patient-assessed severity, QOL, and number of physician encounters.

METHODS: Questionnaires regarding AD severity (e.g., mild, moderate, severe) were mailed to 400 participants identified from the claims database. Adults assessed their QOL using the Dermatology Life Quality Index (DLQI) and the Short Form 36 (SF-36), while children used the Children's Dermatology Life Quality Index (CDLQI). The number of physician visits for AD over the previous 12-